MEDI-CAL UPDATE

Allied Health
Bulletin 338

Billing and Policy
Orthotics and Prosthetics Bulletin 338 December 2003

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Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

HIPAA Implementation: Modifier -LT/-RT Exceptions for O & P

Effective for dates of service on or after September 22, 2003, the following Orthotic and Prosthetic (O & P) procedure codes do not require -LT (left side) and/or -RT (right side) modifiers:

L1500 – L1520	L4000	L8002
L1620	L4205	L8015
L1700	L4210	L8040
L2640	L6360	L8041
L3650	L6384	L8047
L3652	L6570	L8230
L3660	L7360 – L7368	L8310
L3675	L7900	

These codes may be billed without modifiers.

Prosthetic repair and labor codes L7510 and L7520 require an -LT and/or -RT modifier unless the provider indicates in the *Reserved For Local Use* field (Box 19) of the claim, or as an attachment, that the repair is not for a limb prosthesis.

Also effective for dates of service on or after September 22, 2003, lift/build-up codes L3300 – L3334 may be billed with either the modifier -LT (left side) or -RT (right side). Lifts are reimbursable for one side only. Lift/build-up codes are restricted to two billing occurrences in 180 days for the same recipient by any provider.

This information is reflected on manual replacement pages ortho 2, 3 and 10 (Part 2).

HCPCS/CPT-4 Code Updates: Modifications to Select Policies

Many of the medical and reimbursement policies for codes affected by the 2003 HCPCS/CPT-4 update were published in the September 2003 *Medi-Cal Update*. Additional policies are highlighted below. All information is effective for dates of service on or after September 22, 2003.

Please see **Code Updates**, *page 2*

Code Updates *(continued)*

Prior Authorization Changes
"By Report" HCPCS codes L3911 (wrist-hand-finger orthosis, elastic, prefabricated), L5782 (addition to lower limb prosthesis, heavy duty) and L5995 (addition to lower extremity prosthesis, heavy duty) require prior authorization.

Modifiers for Prosthetic Codes
New prosthetic codes K0556 – K0559 require modifiers -LT (left side) and/or -RT (right side). Modifier -RP (replacement or repair) may be used for tracking purposes only. Providers must use codes L7510/L7520 for reimbursement of repairs to prosthetic appliances. Modifier -Y4 (undeliverable custom item, without sales tax) is also allowable, if appropriate. *The updated information is reflected on manual replacement page ortho 2 (Part 2).*

Cranial Molding Helmet Update
HCPCS code S1040 (cranial molding helmet) requires prior authorization, which must include the name and address of the FDA-approved lab that made the helmet. The following are currently approved laboratories:

- Ballert Orthopedic (Cranial Molding Helmet)
- Beverly Hills Prosthetics Orthotics (Cranial Symmetry System)
- Children's Hospital and Regional Medical Center in Seattle, WA (Clarren Helmet)
- Loma Linda University Medical Center, Rehab Institute, Department of O&P (LLUMC Cranial Remolding Helmet)
- Orthomerica in Orlando, FL (STARband, STARlight Cranial Remolding Orthosis, Clarren Helmet)
- Orthotic & Prosthetic Lab, Inc. in Webster Grove, MO (Cranial Molding Helmet)

The updated information is reflected on manual replacement page ortho 8 (Part 2).

Medi-Cal Benefit List Changes
The following HCPCS codes are not Medi-Cal benefits: A4653, E0636, E1802 and S9145.

2004 HCPCS and CPT-4 Codes: Billing Update

The 2004 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and *Healthcare Common Procedure Coding System* (HCPCS Level II codes) will become effective for Medicare on January 1, 2004. Medi-Cal has not yet adopted the 2004 updates. Do not use the 2004 code updates to bill for Medi-Cal services until notified to do so in a future *Medi-Cal Update*.

Reimbursement Update: Durable Medical Equipment and Orthotic Appliances

Effective for dates of service on or after September 22, 2003, the reimbursement rates for the following Durable Medical Equipment (DME) and orthotic appliance codes have been adjusted in compliance with the implementation of State budget Assembly Bill 1762:

HCPCS Code	Description
E0117	Crutch, underarm, articulating, spring assisted, each
E1037	Transport chair, pediatric size
L0462	Three rigid plastic shells, soft liner, includes straps and closures, includes fitting and adjustment

The updated information is reflected on manual replacement pages dura cd 2 and 9 (Part 2) and ortho cd1 2 and 19 (Part 2).

CTP Services Payment Reduction

Effective for dates of service on or after January 1, 2004, reimbursements for Children's Treatment Program (CTP) services will be reduced by 5 percent. The reductions will remain in effect until further notice.

Although CTP services have been identified as exempt from the 5-percent Medi-Cal reimbursement reduction mandated under the Budget Act of 2003 (Assembly Bill 1762), projected CTP expenditures for the 2003-2004 fiscal year currently exceed revenues. Section 16934.5(b)(3)(c) of the *Welfare and Institutions Code* (W & I) states that the CTP may "…adjust payments for the remainder of the fiscal year to providers on a pro rata basis in order to ensure that expenditures do not exceed available revenues."

In addition, the reduction is consistent with the recent action by Medi-Cal to reduce provider reimbursements by 5 percent (refer to this month's Part 1 *Medi-Cal Update*). As stated in the *CTP Medical Services Policies and Procedures Manual*, "Reimbursement is provided at current Medi-Cal rates. (As Medi-Cal increases or reduces the level of reimbursement, CTP level of reimbursement will also change.)"

County Medical Services Program: Rate Adjustment

Effective for dates of service on or after November 1, 2003, the County Medical Services Program (CMSP) implemented a 10 percent rate reduction for services rendered to CMSP recipients. This reduction applies to CMSP recipients with the following aid codes: 50, 84, 85, 88, 89 and 8F. This reduction does not apply to inpatient services.

Remittance Advice Details (RADs) will identify payments affected by these rate reductions with RAD code message 477: "CMSP (County Medical Services Program) reduction cutback."

Note: This reduction is not related to the Medi-Cal reimbursement reduction of 5 percent (required by the *Welfare and Institutions Code* [W&I], Section 14105.19).

Information about this rate reduction is reflected on provider manual replacement page county med 12 of the Part 1 manual.

ICD-9-CM Diagnosis Codes: 2004 Updates

Providers may use the following diagnosis codes for claims with dates of service on or after January 1, 2004. Please refer to the 2004 *International Classification of Diseases, 9th Revision, Clinical Modification, 6th Edition* (ICD-9-CM) for the description of each diagnosis code.

Please see **ICD-9-CM**, *page 4*

ICD-9-CM *(continued)*

Additions

079.82	358.01	728.88	V04.81
255.10	414.07 +	752.81 *	V04.82 ††
255.11	458.21	752.89	V04.89
255.12	458.29	766.21 †	V15.87
255.13	480.3	766.22 †	V25.03 ** ‡
255.14	493.81	767.11 †	V43.21
277.81	493.82	767.19 †	V43.22
277.82	517.3	779.83 †	V45.85
277.83	530.20	780.93	V53.90
277.84	530.21	780.94	V53.91
277.89	530.85	781.94	V53.99
282.41	600.00 *	785.52	V54.01
282.42	600.01 *	788.63	V54.02 §
282.49	600.10 *	790.21	V54.09
282.64	600.11 *	790.22	V58.63
282.68	600.20 *	790.29	V58.64
289.52	600.21 *	799.81 ‡‡	V58.65
289.81	600.90 *	799.89	V64.41
289.82	600.91 *	850.11	V64.42
289.89	607.85 *	850.12	V64.43
331.11 §§	674.50 **	959.11	V65.11 ** ‡
331.19	674.51 **	959.12	V65.19
331.82	674.52 **	959.13 *	V65.46
348.30	674.53 **	959.14	E928.4
348.31	674.54 **	959.19	E928.5
348.39	719.7	996.57	
358.00	728.87	V01.82	

*	Restricted to males	§§	Restricted to ages 0 thru 50 years
**	Restricted to females	‡	Restricted to ages 5 thru 70 years
†	Restricted to ages 0 thru 1 years	‡‡	Restricted to ages 10 thru 99 years
††	Restricted to ages 0 thru 3 years	+	Restricted to ages 40 thru 99 years
§	Restricted to ages 0 thru 21 years		

Revisions

The descriptions for the following ICD-9-CM diagnosis codes are revised: 282.60, 282.61, 282.62, 282.63, 282.69, 414.06, 491.20, 491.21, 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.90, 493.92, V06.1 and V06.5.

Inactive

Effective for dates of service on or after January 1, 2004, the following ICD-9-CM diagnosis codes are inactive and no longer reimbursable: 255.1, 277.8, 282.4, 289.8, 331.1, 348.3, 358.0, 458.2, 530.2, 600.0, 600.1, 600.2, 600.9, 719.70, 719.75, 719.76, 719.77, 719.78, 719.79, 752.8, 766.2, 767.1, 790.2, 799.8, 850.1, 959.1, V04.8, V43.2, V53.9, V54.0, V64.4 and V65.1.

Instructions for Manual Replacement Pages
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Part 2

Remove and replace:
dura cd 1/2 and 7 thru 10
ortho 1 thru 4 and 7 thru 10
ortho cd1 1/2 and 19/20
tar sub clk 1/2 *
tar submis 1/2 *
tax 7/8 *

* Pages updated/corrected due to ongoing provider manual revisions.